4. PROGRAM REGULATIONS

422.401: Introduction

130 CMR 422.000 contains regulations governing personal care services under MassHealth. All personal care agencies and fiscal intermediaries participating in MassHealth must comply with the regulations of the Division governing MassHealth, including, but not limited to, Division regulations at 130 CMR 422.000 and 130 CMR 450.000.

422.402: Definitions

The following terms used in 130 CMR 422.000 have the meanings given in 130 CMR 422.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 422.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 422.000 and in 130 CMR 450.000.

Activities of Daily Living (ADLs)—those specific activities described in 130 CMR 422.410(A) and in the Contract for Personal Care Management (PCM) Services. Such activities are performed by a personal care attendant (PCA) to physically assist a member to transfer, take medications, bathe or groom, dress and undress, engage in passive range of motion exercises, eat, and toilet.

Activity Form—the timesheet developed and distributed by the fiscal intermediary to the member for recording all PCA activity time for each pay period. The member or the member's surrogate submits the activity form to the fiscal intermediary.

Activity Time—the actual amount of time spent by a PCA physically assisting the member with ADLs and Instrumental Activities of Daily Living (IADLs). Activity time is reported on the activity form.

Administrative Tasks—tasks, such as claims processing, recordkeeping, and reporting, required by the Division's fiscal intermediary contract and performed by the fiscal intermediary.

Assessment—a personal care agency's determination of an individual's ability to manage the PCA program independently. The personal care agency conducts the assessment in accordance with 130 CMR 422.422(A) and the contract for PCM services. The result of an assessment is a determination that the member either requires a surrogate to receive PCA services or can manage the PCA program independently.

Consumer—a MassHealth member who is receiving PCA services. The consumer is the employer of the PCA.

Consumer Agreement—A MassHealth-standardized PCA agreement form that the consumer must sign before enrolling with a fiscal intermediary. The consumer agreement describes and identifies the employer option the member selects.

Consumer-Delegated Option (Option One)—one of the two employer options offered by the fiscal intermediary where the consumer chooses to delegate to the fiscal intermediary responsibility for performing the employer-obligations portion of the employer-required tasks.

Consumer-Directed Option (Option Two)—one of the two employer options offered by the fiscal intermediary where the consumer retains responsibility for performing the employer-obligations portion of the employer-required tasks.

Day/Evening Hours—6:00 A.M. to midnight.

Division of Health Care Finance and Policy (DHCFP)—a Division of the Commonwealth of Massachusetts's Executive Office of Health and Human Services created pursuant to M.G.L. c.118G. DHCFP is responsible for determining the rates for the PCA program under 114.3 CMR 9.00 (Independent Living Services for the PCA Program), with the exception of the fiscal intermediary administrative fee.

Employer Expense Component—the portion of the PCA rate designated as reimbursement to members for their mandated employer's share of social security, federal and state taxes, unemployment insurance taxes, Medicare, and worker's compensation premiums.

Employer Option—either the consumer-delegated option or the consumer-directed option.

Employer-Required Tasks—tasks described in the Division's contract with the fiscal intermediary that relate to the member's employment of PCAs, including, but not limited to:
(1) employer obligations, including filing the member's federal and state taxes, withholding PCA taxes, paying unemployment insurance taxes, purchasing worker's compensation insurance, and preparing the PCA payroll (under the consumer-directed option, the consumer fulfills the employer obligations);
(2) payroll responsibilities, including reviewing activity forms and verifying prior-authorization status; and
(3) fiscal functions, including generating and distributing checks.

Evaluation—an initial determination by the personal care agency of the scope and type of personal care services to be provided to a member who meets the qualifications of 130 CMR 422.403. The evaluation is conducted by a registered nurse and an occupational therapist in accordance with 130 CMR 422.422(C) or 422.438(B).

Family Member—a child, spouse, parent, son-in-law, or daughter-in-law of the member.

Fiscal Intermediary—an entity contracting with the Division to perform employer-required tasks and related administrative tasks including, but not limited to, tasks described in 130 CMR 422.419(B).

Functional Skills Training —instructional services provided by a personal care agency in accordance with 130 CMR 422.421(B) to assist members who have obtained prior authorization for PCA services and their surrogates, if necessary, in developing the skills and resources to maximize the member's management of personal health care, personal care services, activities of daily living, and activities related to the fiscal intermediary.

Holidays—New Year's Day (January 1), July 4, Thanksgiving Day, and Christmas (December 25).

Instrumental Activities of Daily Living (IADLs)—those specific activities described in 130 CMR 422.410(B) that are instrumental to the care of the member's health and are performed by a PCA, such as meal preparation and clean-up, housekeeping, laundry, shopping, maintenance of medical equipment, transportation to medical providers, and completion of paperwork required for the member to receive personal care services.

Intake and Orientation Services—services provided to a member who has been referred to a personal care agency for PCA services, but for whom the Division has not yet granted a prior authorization for PCA services. These services include, but are not limited to, determination of eligibility for PCA services; instruction and orientation in the rules, policies, and procedures of the PCA Program; instruction in the member's rights and responsibilities when using PCA services; and instruction in the role of the personal care agency and the fiscal intermediary, including the use of activity forms.

Member— a person determined by the Division to be eligible for MassHealth.

Night Hours—midnight to 6:00 A.M.

Nurse Practitioner—a registered nurse who has successfully completed a formal education program for nurse practitioners as required by the Massachusetts Board of Registration in Nursing, and who is responsible for the oversight of the member's health care. A nurse practitioner who prescribes medication must be certified by the Federal Drug Enforcement Agency (DEA).

Occupational Therapist—a person currently licensed by the Massachusetts Division of Registration in Allied Health Professions and in good standing with the Division of Registration**;** and currently certified by the National Board for Certification in Occupational Therapy and in good standing with the Board.

Overtime—activity time performed by a PCA for one member in excess of 40 hours per work-week.

Passive Range of Motion Exercises (Passive ROM)—movement applied to a joint or extremity by another person solely for the purpose of maintaining or improving the distance and direction through which a joint can move.

Pay Period—two consecutive work-weeks.

PCA Rate—the rate of payment for activity time performed by PCAs during day/evening hours and night hours in accordance with regulations of the Division of Health Care Finance and Policy (DHCFP) at 114.3 CMR 9.00.

PCA Wage Component— the portion of the PCA rate designated as the PCA's gross hourly wage.

Personal Care Agency—a public or private agency or entity under contract with the Division to provide PCM services in accordance with 130 CMR 422.000 and the PCM services contract; or a public or private agency or entity that has been approved by the Division to provide transitional living services covered under 130 CMR 422.431 to 422.441.

Personal Care Attendant (PCA)—a person who meets the requirements of 130 CMR 422.411(A)(1) and who is hired by the member or surrogate to provide PCA services.

Personal Care Attendant Program (PCA Program)—a MassHealth program under which personal care management services, fiscal intermediary services, and PCA services are available to MassHealth members.

Personal Care Attendant Services (PCA Services)—physical assistance with ADLs and IADLs provided to a member by a PCA in accordance with the member's authorized evaluation or reevaluation, service agreement, and 130 CMR 422.410.

Personal Care Management (PCM) Services—services provided by a personal care agency to a member in accordance with a contract with the Division, including, but not limited to, those services identified in the PCM contract and 130 CMR 422.419(A).

Personal Care Services—services provided to an eligible MassHealth member for the purpose of assisting the member to achieve independent living, including PCM services, PCA services, and fiscal intermediary services.

Premium Pay for Overtime—a rate of payment in addition to the regular rate made to a PCA who has performed activity time in excess of 40 hours per work-week for one member. Payment for premium pay for overtime requires prior authorization from the Division and is made in accordance with 130 CMR 422.418(A).

Prior Authorization Period—the dates authorized by the Division designating the duration of services covered by the prior authorization.

Prior Authorization Request (PA Request)—a request to initiate, continue, or adjust a member's prior authorization for PCA services or transitional living services that the personal care agency must submit to the Division in accordance with 130 CMR 422.416, the PCM services contract, or 130 CMR 422.431. The Division may approve, deny, modify, or defer a PA request.

Reevaluation—a determination of the scope and type of PCA services to be provided to a consumer who requests a continuance of PCA services, because the current authorization is expiring. The reevaluation must be conducted in accordance with 130 CMR 422.422(D).

Registered Nurse—a person currently licensed as a registered nurse by the Massachusetts Board of Registration in Nursing and in good standing with the Board.

Service Agreement (previously known as the Personal Care Services Plan)—a written plan of services, consistent with the requirements of 130 CMR 422.423 and the PCM services contract, that is developed jointly by the personal care agency, the member, and the member's surrogate, if any. The service agreement describes the responsibilities of the PCA, the member, the surrogate, the fiscal intermediary, and the personal care agency as they relate to the management of the member's PCA program If the member does not require a surrogate, the service agreement must state that the member is solely responsible for the management tasks, including hiring, firing, scheduling, training, supervising, and otherwise directing PCAs. The service agreement must also describe the type and frequency of functional skills training that the member and the surrogate, if appropriate, require from the personal care agency to manage the PCA program successfully.

Surrogate—the member's legal guardian, a family member, or other person as identified in the service agreement, who is responsible for performing certain PCA management tasks that the member is unable to perform. These tasks must be described in the member's service agreement, and must be performed in accordance with Division regulations. These PCA management tasks may include signing and submitting activity forms, hiring, firing, supervising, and otherwise directing the PCA as specified in the member's service agreement. A member's surrogate cannot also be the PCA or an employee or a contractor of either the member's fiscal intermediary or the member's personal care agency. The surrogate must live in proximity to the member and be readily available to perform the tasks described in the service agreement.

Transitional Living Program—a program of services that may be offered by an organization in a structured group-living environment, for persons with severe disabilities who demonstrate an aptitude for independent living, but who can clearly benefit from functional skills training and supervised experience in management of health care, PCA services, and community activity in gaining the ability and confidence necessary to achieve independent living.

Work Week—a seven-day period ending at midnight on Saturday.

422.403: Eligible Members

(A) (1) MassHealth Members. The Division covers personal care services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. 130 CMR 450.105 specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

(C) The Division covers personal care services provided to eligible MassHealth members who can be appropriately cared for in the home when all of the following conditions are met:
(1) The personal care services are prescribed by a physician or a nurse practitioner who is responsible for the oversight of the member's health care.
(2) The member's disability is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance.
(3) The member, as determined by the personal care agency, requires physical assistance with two or more of the following ADLs as defined in 130 CMR 422.410(A):
(a) mobility, including transfers;
(b) medications,
(c) bathing or grooming;
(d) dressing or undressing;
(e) range-of-motion exercises;
(f) eating; and
(g) toileting.
(4) The Division has determined that the PCA services are medically necessary and has granted a prior authorization for PCA services.

422.404: Provider Eligibility

(A) Provider Qualifications.

(1) Providers of PCM Services. To provide PCM services described in 130 CMR 422.419(A) and the PCM services contract to eligible members, the personal care agency must:

(a) meet the applicant qualifications described in the PCM services Request for Applications (RFA);

(b) have the capability and willingness to perform all of the functions detailed in the RFA and the contract with the Division;

(c) enter into a contract with the Division to provide PCM services;

(d) select a fiscal intermediary and forward its selection to the Division; and

(e) obtain a MassHealth provider number.

(2) Providers of Fiscal Intermediary Services. An organization may apply to be a fiscal intermediary only at the time that the Division issues a request for responses. To provide fiscal intermediary services described in 130 CMR 422.419(B), the fiscal intermediary must:

(a) meet the financial, business, and program requirements described in the fiscal intermediary Request for Responses (RFR);

(b) have the capability and willingness to perform all of the functions detailed in the RFR and the contract with the Division;

(c) enter into a contract with the Division to provide fiscal intermediary services; and

(d) obtain a MassHealth provider number .

(3) Providers of Transitional Living Services. To provide transitional living services described in 130 CMR 422.431 through 422.441, the organization must:

(a) submit a proposal for review by the Division in accordance with the Division's proposal requirements;

(b) obtain written authorization from the Division to become a MassHealth provider of transitional living services;

(c) demonstrate the appropriate licensure or program accreditation by a recognized body for the provider's type of program; and

(d) obtain a MassHealth provider number.

(B) Scope of Services.

(1) Personal Care Management (PCM) Services.

(a) The member selects the personal care agency who will conduct the PCA evaluation and provide PCM services. Personal care agencies who contract with the Division to provide PCM services must provide a range of services to meet the personal care needs of persons with disabilities in accordance with the PCM services contract and with 130 CMR 422.000. Services must include, but are not limited to, those described in 130 CMR 422.419(A).

(b) The Division may reassign a member to another personal care agency selected by the Division, if, in the sole determination of the Division, the personal care agency selected by the member:

(i) becomes unavailable for any reason;

(ii) is unable or unwilling to provide PCM services pursuant to the requirements set forth in 130 CMR 422.000; or

(iii) is not in compliance with its obligations as set forth in its contract with the Division.

(2) Fiscal Intermediary Services. Organizations that contract with the Division to provide fiscal intermediary services must provide services in accordance with the fiscal intermediary contract and with 130 CMR 422.000. Services must include, but are not limited to, those described in 130 CMR 422.419(B).

(3) Transitional Living Services. Organizations that provide transitional living services must provide services in accordance with 130 CMR 422.431 through 422.441, and in accordance with the Division's proposal requirements for transitional living services.

(C) Fiscal Intermediaries

(1) Selecting a Fiscal Intermediary. As a condition of participating in MassHealth as a personal care agency that does not exclusively provide transitional living services under 130 CMR 422.431 through 422.441, the personal care agency must select one fiscal intermediary from the Division's list of approved fiscal intermediaries for all eligible MassHealth members that the personal care agency serves and notify the Division in writing of the selection. Requests by personal care agencies to change fiscal intermediaries must be made in writing and approved by the Division in accordance with 130 CMR 422.419(A)(17)(i).

(2) Reassignment to a Fiscal Intermediary. The Division may reassign personal care agencies to a fiscal intermediary selected by the Division, if, in the sole determination of the Division, the fiscal intermediary selected by such personal care agency:

(a) becomes unavailable for any reason;

(b) is unable or unwilling to provide fiscal intermediary services pursuant to the requirements set forth in 130 CMR 422.000 and 450.000; or

(c) is not in compliance with its obligations as set forth in its contract with the Division.

(130 CMR 422.405 through 422.409 Reserved)

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422.410: Activities of Daily Living and Instrumental Activities of Daily Living

(A) Activities of Daily Living (ADLs). Activities of daily living include the following:
(1) mobility: physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
(2) assistance with medications or other health-related needs: physically assisting a member to take medications prescribed by a physician that otherwise would be self-administered;
(3) bathing or grooming: physically assisting a member with basic care such as bathing, personal hygiene, and grooming skills;
(4) dressing or undressing: physically assisting a member to dress or undress;
(5) passive range-of-motion exercises: physically assisting a member to perform range-of-motion exercises;
(6) eating: physically assisting a member to eat. This can include assistance with tube-feeding and special nutritional and dietary needs; and
(7) toileting: physically assisting a member with bowel and bladder needs.

(B) Instrumental Activities of Daily Living (IADLs). Instrumental activities of daily living include the following:
(1) household services: physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;
(2) meal preparation and clean-up: physically assisting a member to prepare meals;
(3) transportation: accompanying the member to medical providers; and
(4) special needs: assisting the member with:
(a) the care and maintenance of wheelchairs and adaptive devices;
(b) completing the paperwork required for receiving personal care services; and
(c) other special needs approved by the Division as being instrumental to the health care of the member.

(C) In determining the number of hours of physical assistance that a member requires under 130 CMR 422.410(B) for IADLs, the personal care agency must assume the following.
(1) When a member is living with family members, the family members will provide assistance with most IADLs. For example, routine laundry, housekeeping, shopping, and meal preparation and clean-up should include those needs of the member.
(2) When a member is living with one or more other members who are authorized for MassHealth personal care services, PCA time for homemaking tasks (such as shopping, housekeeping, laundry, and meal preparation and clean-up) must be calculated on a shared basis.
(3) The Division will consider individual circumstances when determining the number of hours of physical assistance that a member requires for IADLs.

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422.411: Covered Services

Rates for payment for all personal care services are set by DHCFP pursuant to 14.3 CMR 9.00.

(A) MassHealth covers the following fiscal intermediary and PCA services:
(1) activity time specified in the evaluation described in 130 CMR 422.422(C) and (D), authorized by the Division, and performed by a PCA who is:
(a) not a family member, as defined in 130 CMR 422.402;
(b) not the member's surrogate;
(c) not the member's legal guardian, foster parent, or step-parent;
(d) legally authorized to work in the United States;
(e) able to understand and carry out directions given by the member or the member's surrogate;
(f) willing to receive training and supervision in all PCA services from the member or the member's surrogate; and
(g) not receiving compensation from any other entity for that activity time except where such entity:
(i) is nonprofit;
(ii) does not receive funds from any state agency other than MassHealth; and
(iii) has a board of directors consisting of at least 51 percent members, family members, and/or siblings of members;
(2) premium pay for overtime in accordance with 130 CMR 422.418(A);
(3) payment for juror service performed by a PCA in accordance with 130 CMR 422.418(B); and
(4) PCA holiday rate established by DHCFP at 114.3 CMR 9.00 for activity time authorized by the Division and performed between the hours of 6:00 A.M. and midnight on Christmas (December 25), New Year's Day (January 1), July 4, and Thanksgiving.

(B) MassHealth covers personal care management services provided by a personal care agency in accordance with 130 CMR 422.000 and the PCM services contract with the Division.

(C) MassHealth pays for services provided by the fiscal intermediary in accordance with 130 CMR 422.419(B) and the contract between the Division and the fiscal intermediary.

(D) MassHealth covers transitional living services provided by an organization in accordance with 130 CMR 422.431 through 422.441 and the Division's proposal requirements.

422.412: Noncovered Services

The Division does not cover any of the following as part of the PCA program or the transitional living program:

(A) social services, including, but not limited to, babysitting, respite care, vocational rehabilitation, sheltered workshop, educational services, recreational services, advocacy, and liaison services with other agencies;

(B) medical services available from other MassHealth providers, such as physician, pharmacy, or community health center services;

(C) assistance provided in the form of cueing, prompting, supervision, guiding, or coaching;

(D) PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility;

(E) PCA services provided to a member during the time a member is participating in a community program funded by MassHealth including, but not limited to, day habilitation, adult day health, adult foster care, or group adult foster care;

(F) services provided by family members, as defined in 130 CMR 422.402; or

(G) surrogates, as defined in 130 CMR 422.402.

(130 CMR 422.413 through 422.415 Reserved)

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422.416: PCA Program: Prior Authorization

The personal care agency must request prior authorization from the Division as a prerequisite to payment for PCA services. Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or utilization of other potential sources of health care as described in 130 CMR 503.007 and 130 CMR 517.008. All requests for prior authorization for PCA services must include the provider number of the fiscal intermediary selected by the personal care agency pursuant to 130 CMR 422.404(C) and be submitted on the Division's forms in accordance with the billing instructions in Subchapter 5 of the *Personal Care Manual* and 130 CMR 422.416. The Division responds to requests for prior authorization in accordance with 130 CMR 450.303.

(A) Initial Request for Prior Authorization for PCA Services.

(1) With the exception of 130 CMR 422.416(D), personal care agencies must submit the initial request for prior authorization for PCA services to the Division within 45 calendar days of the date of the member's referral to the personal care agency for PCA services. Requests for prior authorization for PCA services must include:

(a) the completed MassHealth Application for PCA Services and MassHealth Evaluation for PCA Services;

(b) the completed Division of Medical Assistance Prior Authorization Request form ;

(c) any documentation that supports the member's need for PCA services; and

(d) documentation that the member's physician or nurse practitioner has ordered PCA services. This documentation may be:

(i) the completed and signed physician/nurse practitioner sign-off page of the MassHealth PCA evaluation form; or

(ii) documentation that the nurse who conducted the evaluation obtained verbal authorization to initiate (or continue) PCA services from the member's physician or nurse practitioner. Such documentation must include the member's name and address, the name and telephone number of the nurse who obtained the authorization, the date the authorization was obtained, the number of PCA hours requested by the personal care agency and ordered by the physician or nurse practitioner, and the name, address, and telephone number of the physician or nurse practitioner who granted the authorization.

(2) If the personal care agency submits the request for PCA services to the Division with documentation described under 422.416(A)(1)(d)(ii), the personal care agency must obtain the completed and signed physician/nurse practitioner sign-off page of the MassHealth evaluation within 60 days of the date that the prior authorization request to initiate (or continue) PCA services is sent to the Division. The personal care agency must maintain the physician/nurse practitioner sign-off page in the member's file, making it available to the Division on request.

(B) Adjustment of Current Prior Authorization. Prior-authorization requests to increase or decrease the number of hours of PCA services must be in writing and include:

(1) a copy of the original prior-authorization request and PCA evaluation;

(2) a written summary of the specific adjustment requested that includes the reason for the adjustment and the specific ADLs or IADLs for which an increase or decrease in PCA services is being requested, including the number of units, the number of hours, and the duration of time for which the adjustment is being requested; and

(3) a letter from the member's physician or nurse practitioner stating that the need for an adjustment in the member's authorized number of hours of PCA services is a result of changes in the member's medical condition, functional status, or living situation that affects the member's ability to perform ADLs and IADLs without physical assistance. The letter must also describe these conditions. The letter must include the length of time for which the adjustment is required.

(C) Continuation of PCA Services. To ensure the continuation of PCA services, personal care agencies must request prior authorization from the Division at least 21 days before the expiration date of the current prior- authorization period. The personal care agency must include in its prior-authorization request the documentation described in 130 CMR 422.416(A)(1)(a) through (d). The Division will continue to pay for PCA services during its review of the new PA request only if the Division has received the new prior-authorization request at least 21 days prior to the expiration of the current prior-authorization period. If the Division does not receive the new prior-authorization request at least 21 days before the expiration date, the Division may stop payment for PCA services after the expiration date.

(D) Special Conditions.

(1)(a) The Division reserves the right to conduct the PCA evaluation for purposes of authorizing PCA services or coordinating other MassHealth services, as appropriate. When the Division conducts a PCA evaluation and authorizes PCA services for the member, the member will select the personal care agency that will be responsible for providing PCM services. The Division will provide written notification to the personal care agency selected by the member, who must provide all other PCM services, as appropriate, including, but not limited to, providing orientation services, functional skills training, and developing, in conjunction with the member, a service agreement.

(b) When the Division conducts an evaluation of the member's need for PCA services, the Division will not pay a personal care agency for an evaluation.

(2) The personal care agency must contact the Division within 24 hours of a referral for PCA services for a member who is being discharged from a nursing facility or other inpatient facility. The Division may, at its discretion, exercise its right to conduct the PCA evaluation and coordinate other MassHealth services in accordance with 130 CMR 422.416(D).

(E) Utilization.

(1) Day/Evening PCA Services. If the Division approves or modifies a prior-authorization request for day/evening PCA services, the notice to the member will specify the number of day/evening hours of PCA services that the Division determines are medically necessary and reimbursable by MassHealth at the PCA rate for each week during the duration of the member's prior-authorization period.

(2) Night PCA Services. If the Division approves or modifies a prior-authorization request for night PCA services, the notice to the member will specify the number of night hours of PCA services that the Division determines are medically necessary and reimbursable by MassHealth at the PCA rate for each night during the member's prior-authorization period.

(3) Adjustments to PCA Hours. Personal care agencies may request an adjustment to the member's authorized number of day/evening PCA services or night PCA services if there is a change in the member's medical or functional status that affects the member's ability to perform ADLs or IADLs without physical assistance. See 130 CMR 422.416(B).

(4) Overutilization.

(a) The fiscal intermediary will notify the member and the personal care agency when the member repeatedly submits activity forms in excess of the day/evening hours per week or night hours per night that the Division has authorized pursuant to 130 CMR 422.416(E).

(b) When contacted by the fiscal intermediary pursuant to 130 CMR 422.416(E)(4)(a), the personal care agency will provide functional skills training to the member or surrogate, if appropriate, to, at minimum:

(i) inform the member or surrogate of the member's or surrogate's responsibility to utilize PCA services in accordance with the number of day/evening hours per week and night hours per night authorized by the Division pursuant to 130 CMR 422.416(E) and provide instruction regarding proper submission of activity forms, as appropriate; and

(ii) inform the member that the member may, if appropriate, request an adjustment in accordance with 130 CMR 422.416(B).

(c) If the member continues to overutilize PCA services after intervention from the fiscal intermediary and the personal care agency in accordance with 130 CMR 422.416(E)(4)(a) and (b), the fiscal intermediary will notify the Division.

(d) The Division reserves the right to take action to ensure that the PCA services reimbursed by the Division are medically necessary, including, but not limited to, directing the fiscal intermediary to stop payment of day/evening hours or night hours submitted on the activity form that are in excess of the number of day/evening hours per week or night hours per night authorized by the Division pursuant to 130 CMR 422.416(E).

(e) The Division, the fiscal intermediary, and the personal care agency are not responsible for reimbursement of PCA services provided to a member in excess of the total number of hours authorized by the Division during a prior-authorization period.

422.417: PCA Program: Notice of Approval, Denial, or Modification of Prior-Authorization Request

(A) Notice of Approval. If the Division approves a PA request for PCA services, the Division will send written notice to the member and the fiscal intermediary regarding the frequency, duration, and intensity of care authorized, as well as the expiration date of the authorization. The fiscal intermediary must notify the personal care agency within two business days of the Division's decision by forwarding a copy of the approved PA request to the personal care agency.

(B) Notice of Denial or Modification and Right of Appeal.

(1) If the Division denies or modifies a prior-authorization request for PCA services, the Division will send written notice to both the member and the fiscal intermediary. The notice will state the reason for the denial or modification and will inform the member of the right to appeal and of the appeal procedure. The fiscal intermediary must notify the personal care agency within two business days of receipt of the Division's decision by forwarding a copy of the Division's notice to the personal care agency.

(2) If the Division denies or modifies a prior-authorization request for PCA services, a member may appeal by requesting a fair hearing. The request for a fair hearing must be made in writing to the Division's Board of Hearings in accordance with the time lines described in 130 CMR 610.015(B). Requests for continuation of services during an appeal must be made in accordance with 130 CMR 610.036. The Division's Board of Hearings will conduct the fair hearing in accordance with 130 CMR 610.000.

422.418: PCA Program: Special Payments

(A) Premium Pay for Overtime. The personal care agency must request authorization from the Division prior to payment for all requests for premium pay for overtime, as defined in 130 CMR 422.402.

(1) Member Responsibility. The member must immediately notify the personal care agency of the request for premium pay for overtime in accordance with 130 CMR 422.420(A)(13) and provide the personal care agency with any information needed to submit the request to the Division. If the request for premium pay for overtime occurs during non-business hours, the member must notify the personal care agency's 24-hour messaging service.

(2) Personal Care Agency Responsibility. When notified that a member has requested premium pay for overtime, the personal care agency must request authorization before payment from the Division within two business days after the member's request. The request to the Division must include the work-week within which the personal care attendant worked overtime, the name of the personal care attendant who worked the overtime, the number of overtime hours requested, and a description of how the request fulfills the conditions for payment in 130 CMR 422.418(A)(3). The personal care agency must document the request in writing to the Division within seven calendar days after the member's request.

(3) Conditions for Payment.

(a) The Division authorizes premium pay for overtime when all of the following conditions are met:

(i) an unforeseen event occurred that prevented the member's regularly scheduled PCA from providing PCA services to the member, resulting in an immediate need for another PCA to provide PCA services for the member in excess of 40 hours for that week;

(ii) the member has demonstrated, to the satisfaction of the Division, that the member has attempted to contact, at a minimum, all persons who are either employed by the member or listed as available in an emergency in accordance with 130 CMR 422.419(A)(15) and 422.420(A)(15);

(iii) The request meets the requirements of 130 CMR 422.418(A)(1) and (2).

(b) The Division may, at its discretion, request additional information to authorize premium pay for overtime including, but not limited to:

(i) the member's PCA schedule for a specific work-week that includes the names of all PCAs employed by the member and the name of the regularly scheduled PCA that was unable to provide PCA services;

(ii) documentation that demonstrates, to the satisfaction of the Division, that the member has attempted to hire PCAs to replace a PCA that has suddenly quit or is otherwise unavailable to work; and

(iii) the list of PCAs contacted in accordance with 130 CMR 422.418(A)(3)(ii).

(c) Regular time will be paid by the Division for any overtime where no authorization was obtained before payment in accordance with the billing instructions in Subchapter 5 of the *Personal Care Manual* and where all other conditions for payment are met.

(4) Notification to the Member and Fiscal Intermediary.

(a) Notice of Approval. If the Division approves a request for premium pay for overtime, it will send written notice to both the member and the fiscal intermediary. The fiscal intermediary must notify the personal care agency within two business days of receipt of the Division's decision by forwarding a copy of the Division's notice to the personal care agency.

(b) Notice of Denial or Modification. If the Division denies or modifies a request for premium pay for overtime, the Division will notify both the member and the fiscal intermediary. The notice will state the reason for the denial and will inform the member of the right to appeal and of the appeal procedure. The fiscal intermediary must notify the personal care agency within two business days of receipt of the Division's decision by forwarding a copy of the Division's notice to the personal care agency.

(c) Request for Fair Hearing. If the Division denies or modifies a request for premium pay for overtime, a member may appeal by requesting a fair hearing. The request for a fair hearing must be made in writing to the Division's Board of Hearings in accordance with the time lines described in 130 CMR 610.015(B). Requests for continuation of services during an appeal must be made in accordance with 130 CMR 610.036. The Division's Board of Hearings will conduct the fair hearing in accordance with 130 CMR 610.000.

(B) Juror Service Performed by a Personal Care Attendant. MassHealth provides reimbursement to members for personal care attendants who are required to perform juror service during regularly scheduled work hours for a maximum of three days when the following conditions are met.

(1) Member Responsibility. Within 14 calendar days of the personal care agency's receipt of documentation from the state or federal court that the personal care attendant has performed juror service, the member must provide the personal care agency with:

(a) the number of hours that the personal care attendant was regularly scheduled to work during the time juror service was required; and

(b) documentation from the appropriate state or federal court that the personal care attendant has performed juror service. This documentation must consist of either:

(i) for state jury service, a copy of the Certificate of Juror Service issued by the Massachusetts Office of the Jury Commissioner, verifying the date(s) that the PCA has been called for juror service; or

(ii) for federal jury service, a copy of the Attendance Sheet issued by the Federal District Court, verifying the date or dates that the personal care attendant has been called for juror service.

(2) Personal Care Agency Responsibility. Within three calendar days of receipt of the required documentation from the member in accordance with 130 CMR 422.418(B)(1), the personal care agency must forward to the Division:

(a) a written request for an increase in the number of hours of personal care attendant services based on the number of hours of juror service performed by the personal care attendant during regularly scheduled work hours, but no greater than three working days; and

(b) documentation provided by the member as specified in 130 CMR 422.418(B)(1).

(3) Conditions for Payment. The Division will provide reimbursement to members for regular rates paid to personal care attendants who performed juror service up to the first three days of juror service provided the following conditions are met:

(a) the time that the personal care attendant is required to perform juror service must occur during the same time that the personal care attendant was regularly scheduled to work for the member;

(b) the number of hours requested for reimbursement by the member for juror service performed by a personal care attendant must not be greater than the number of hours the personal care attendant was regularly scheduled to work for the member; and

(c) all the requirements in 130 CMR 422.418(B) must be met.

422.419: PCA Program: Scope of Services

(A) The Personal Care Agency. The personal care agency must provide personal care management services in accordance with 130 CMR 422.000 and its contract with the Division, including, but not limited to:

(1) maintaining a communication system that is accessible to members on a 24-hour basis;
(2) responding to member inquiries regarding the Division's prior-authorization decisions within the timeframes specified in the contract and in 130 CMR 422.000;
(3) maintaining records in accordance with 130 CMR 422.446 and the PCM contract;
(4) conducting a formal, written assessment of the member's ability to manage the PCA program independently in accordance with 422.422(A) and the PCM contract, and in a standard format approved by the Division;
(5) performing evaluations and reevaluations of members who are eligible for personal care services in accordance with 130 CMR 422.422(C) and (D) and the PCM contract;
(6) submitting to the Division all requests for prior authorization for PCA services in accordance with the procedures and timelines identified in the PCM contract, 130 CMR 422.416(A), (B), and (C), and 130 CMR 422.418;
(7) developing in conjunction with the member and the member's surrogate, if any, a formal, written service agreement for the member in accordance with 130 CMR 422.423 and the PCM contract, and in a standard format approved by the Division;
(8) providing intake and orientation services to determine a member's initial eligibility for PCA services, and to instruct the member in the rules, policies, and regulations of the PCA program in accordance with 130 CMR 422.421(A) and the PCM contract;
(9) providing functional skills training to instruct the member and the surrogate, if necessary, in the basic requisites of an effective program of personal care services in accordance with 130 CMR 422.421(B) and the PCM contract;
(10) maintaining policies and procedures for the receipt and timely resolution of member complaints in accordance with the PCM contract;
(11) providing written information to members in a language and format that is understandable to them;
(12) providing PCM services that are culturally sensitive;
(13) seeking out and including member input and feedback into the PCM services provided by the personal care agency;
(14) educating members and surrogates about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Investigation (CORI), Disabled Persons Protection Commission (DPPC), the sex offender registry, and the Elder Services hotline;
(15) working with the member to establish a list of PCAs who can be contacted when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services;

(16) developing creative methods to assist members in the recruitment of PCAs;
(17) establishing a cooperative working relationship with the fiscal intermediary by:
(a) choosing one fiscal intermediary for all members served by the personal care agency and notifying the Division of the choice;
(b) informing new members of the fiscal intermediary and assisting them to enroll with them before hiring personal care attendants;
(c) educating members about the role of the fiscal intermediary;
(d) assisting members to select one of the employer options in 130 CMR 422.419(B)(1);
(e) working with the fiscal intermediary to resolve member and PCA complaints;
(f) sharing information with the fiscal intermediary, as needed, about the status of a member's prior-authorization decision, including, but not limited to, the member's name, address, and date of birth;
(g) providing the fiscal intermediary with the name, address, and phone number of the member's surrogate, if any; and any changes in the surrogate information;
(h) responding to the fiscal intermediary's request for skills training for a member or surrogate who is having difficulty managing the PCA program, including, but not limited to, a member or surrogate who repeatedly submits activity forms in excess of the day/evening hours per week or night hours per night authorized by the Division pursuant to 130 CMR 422.416(E);
(i) notifying the Division in writing at least 60 days in advance of a request to change fiscal intermediaries. The personal care agency must continue to use its current fiscal intermediary until notified by the Division that its request to change fiscal intermediaries has been approved. If the request is approved, the personal care agency must cooperate with the Division and the current fiscal intermediary to ensure a smooth transition to the new fiscal intermediary;
(18) reporting suspicion of fraud to the Division in the format specified by the Division and cooperating with any subsequent investigation;
(19) if the Division reassigns a personal care agency to a new fiscal intermediary, cooperating with the Division, the new fiscal intermediary, and the current fiscal intermediary to ensure a smooth transition to the new fiscal intermediary; and
(20) notifying the Division if, in the opinion of the personal care agency, the member's surrogate is not managing PCA tasks for the member in accordance with Division regulations.

(B) The Fiscal Intermediary. The fiscal intermediary must ensure that each member it serves has a current prior authorization for PCA services from the Division. The fiscal intermediary must fulfill its responsibilities in accordance with its contract with the Division, including, but not limited to, the following:

(1) offering a choice of the following employer options to members:

(a) the consumer-delegated option, as defined in 130 CMR 422.402, for members who choose to delegate responsibility for the employer-obligations portion of the employer-required tasks to the fiscal intermediary; or

(b) the consumer-directed option, as defined in 130 CMR 422.402, for members who choose to retain responsibility for performing the employer-obligations portion of the employer-required tasks;

(2) obtaining the signed MassHealth consumer agreement from each member that identifies the employer option chosen by the member and describes the roles and responsibilities of both the member and the fiscal intermediary;

(3) establishing a member services unit with staff trained to answer member telephone calls about activity forms, tax forms, and the functions of the fiscal intermediary. When member concerns cannot be resolved by telephone, the member can be referred to a personal care agency for functional skills instruction (see also 130 CMR 419(A)(17)(h) and 422.421(B)(2)).

(4) operating a toll-free telephone service during business hours (from 9:00 A.M. to 5:00 P.M., Monday through Friday, holidays excluded);

(5) operating a toll-free answering or voice messaging service during non-business hours;

(6) in conjunction with the personal care agency, establishing systems to resolve member and PCA complaints in a timely fashion;

(7) sharing information regarding a member's prior authorization with the personal care agency, including notifying the personal care agency when a member is repeatedly submitting Activity Forms in excess of the day/evening hours per week or night hours per night authorized by the Division.

(8) establishing cooperative working relationships with personal care agencies;

(9) developing, using, and distributing standardized activity forms and schedules to document the use of PCAs and to meet the requirements for reimbursement;

(10) reviewing PCA activity forms to ensure accuracy;

(11) processing all claims for PCA services;

(12) under the consumer-directed option only:

(a) issuing one check to the member that includes both the PCA wage component and the employer expense component of the PCA rate; and

(b) issuing, by February 1 of each calendar year, a statement to the member that identifies the total amount of funds that the fiscal intermediary paid to the member during the calendar year, sorted by procedure code and service description, and identifying the rate paid for each code; and

(c) obtaining at least annually from the member documentation that the member has complied with all legally mandated employer-required tasks as defined in 130 CMR 422.402 and has accounted for all funds paid by the fiscal intermediary during the calendar year, as described in 422.419(B)(13)(b);

(13) under the consumer-delegated option only:
(a) developing and distributing to members an employment package that includes a user-friendly personnel form, all required employer and employee federal and state tax forms, other employment-related forms, and instructions in their use; and
(b) issuing checks for PCAs equal to the PCA wage component of the PCA rate, with appropriate taxes withheld;
(14) reporting suspicion of fraud to the Division in the format requested by the Division and cooperating with any subsequent investigation;
(15) in the event that a personal care agency requests and is approved by the Division to transfer fiscal intermediaries in accordance with 422.419(A)(17)(i), cooperating with the Division, the personal care agency, and the new fiscal intermediary to ensure a smooth transition of all necessary records and documentation in the timeframes and format specified by the Division; and
(16) in the event that the Division reassigns a personal care agency to another fiscal intermediary pursuant to 130 CMR 422.303(C)(2), cooperating with the Division, the personal care agency, and the new fiscal intermediary to ensure a smooth transition of all necessary records and documentation in the time frames and format specified by the Division.

422.420: PCA Program: Member Responsibilities

(A) As a condition of receiving MassHealth PCA services, the member must:
(1) select an employer option, either the consumer-delegated option or the consumer-directed option, as defined in 130 CMR 422.402, by completing and signing the standard consumer agreement supplied by the fiscal intermediary. Members who have a surrogate in accordance with 130 CMR 422.422(B)(1) must select the consumer-delegated option unless the member has a court-appointed legal guardian or is the minor child of a parent with legal custody. Members must give the fiscal intermediary at least 10 days' notice to change employer options;
(2) complete and sign all employment forms required by the fiscal intermediary;
(3) complete and sign activity forms and submit them to the fiscal intermediary in accordance with the instructions provided and time frame specified by the fiscal intermediary;
(4) ensure that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services, and the correct hours and dates that the PCA services were provided;
(5) employ personal care attendants for no more than the number of PCA hours authorized by the Division in accordance with 130 CMR 422.416(E), and only to provide physical assistance with ADLs and IADLs as described in the personal care attendant evaluation submitted by the personal care agency and authorized by the Division;
(6) hire, fire, schedule, and train personal care attendants;
(7) employ personal care attendants who meet the requirements of 130 CMR 422.411(A)(1);

(8) under the consumer delegated option only, inform personal care attendants of the option to have PCA payments direct-deposited into the personal care attendant's bank account and notify the fiscal intermediary of the personal care attendant's choice;
(9) cooperate with the Division and the personal care agency during assessments, evaluations, and reevaluations;
(10) notify the fiscal intermediary of the date of hire and the date of termination of the member's personal care attendants and of a personal care attendant's change of address;
(11) notify the Division and the fiscal intermediary of the member's change of address;
(12) notify the personal care agency when there is a change in the member's medical condition or living situation that may require an adjustment in the number of day/evening hours per week or night hours per night authorized by the Division;
(13) contact the personal care agency to make requests for prior authorization for premium pay for overtime according to conditions described in 130 CMR 422.418(A)(3);
(14) contact the personal care agency to request payment for juror service for a PCA in accordance with 130 CMR 422.418(B);
(15) work with the personal care agency to establish a list of PCAs who can be contacted when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing PCA services.;
(16) work with the fiscal intermediary and the personal care agency to resolve any issues or complaints;
(17) review and sign the evaluation or reevaluation prepared by the personal care agency in accordance with 130 CMR 422.422(C) and (D);
(18) under the consumer-directed option only:

(a) upon request and at least annually, provide the fiscal intermediary with documentation requested by the fiscal intermediary to verify compliance with employer obligations and proper use of MassHealth PCA funds. Such documentation may include, but is not limited to, copies of W-2s issued to PCAs, proof of payment of federal and state taxes, proof of payment of unemployment insurance taxes, and proof of purchase of workers' compensation insurance for PCAs;
(b) pay PCAs the PCA wage component of the PCA rate, with the appropriate taxes withheld, in accordance with the rates set by DHCFP at 114.3 CMR 9.00;
(c) use all funds identified as the employer's expense component of the PCA rate to pay employer obligations; and
(d) pay the premium pay for overtime when authorized by the Division in accordance with 130 CMR 422.418(A) and DHCFP at 114.3 CMR 9.00;

(19) comply with all applicable state and federal labor laws, including, but not limited to, federal and state child labor laws; and
(20) comply with all applicable Division regulations.

(B) The Division reserves the right to:

(1) terminate PCA services if a member fails to comply with any of the requirements listed in 422.420(A);

(2) require a member who has chosen the consumer-directed employer option to change to the consumer-delegated employer option as a condition of continuing to receive PCA services if a member fails to comply with any of the requirements listed in 130 CMR 422.420(A);

(3) terminate PCA services if a member's surrogate becomes unavailable, or the Division requires the member to replace the current surrogate, and another surrogate cannot be identified within 30 days of the PCA agency's notification to the member and the Division in accordance with 130 CMR 422.422(B);

(4) require a member who is receiving PCA services to obtain a surrogate to continue to receive PCA services if the personal care agency or the Division determines, based on an assessment conducted in accordance with 130 CMR 422.422(A), that the member is not able to manage the PCA program independently. The Division will terminate PCA services if the member does not obtain a surrogate within 30 days of the date of the personal care agency's assessment, and the personal care agency will refer the member to an appropriate service provider; and

(5) require a member to replace the surrogate if the surrogate is not performing PCA tasks on behalf of the member in accordance with Division regulations and after intervention from a skills trainer pursuant to 130 CMR 422.419(A)(17)(h).

422.421: PCA Program: Intake and Orientation and Functional Skills Training

(A) Intake and Orientation Services. Intake and orientation services are provided to members who are referred to the personal care agency and do not yet have a prior authorization for PCA services. The personal care agency must ensure that each member who is referred for PCA services receives sufficient face-to-face orientation to the PCA program to ensure that the member, or surrogate, if any, understands the rules, policies, and procedures of the PCA program. The personal care agency must provide intake and orientation services to the member that include, but are not limited to, the following:

(1) responding, either by telephone or in person, to an initial request for PCA services within two business days of the member's referral to the personal care agency for PCA services;

(2) completing a face-to-face determination of the member's eligibility for the PCA program within 10 business days of the member's referral to the personal care agency in accordance with 130 CMR 422.403 and the PCM services contract;

(3) ensuring that the member is eligible for MassHealth and meets the eligibility criteria for PCA services as described in 130 CMR 422.403(C)(1) through (4);

(4) providing face-to-face orientation to each member that is eligible for the PCA program but has not yet been granted a prior authorization for PCA services that includes, at minimum:

(a) a description of the member's rights and responsibilities when using the PCA program, including the member's responsibilities defined under 130 CMR 422.420(A);

(b) the rules, regulations, and policies governing the PCA program, including, but not limited to, the member's responsibility to use PCA services as authorized by the Division pursuant to 130 CMR 422.416(E);

(c) the roles and responsibilities of the personal care agency and the fiscal intermediary; and

(d) the appropriate use of activity forms;

(5) informing the member of the member's responsibility for enrolling with the fiscal intermediary before employing PCAs and assist the member with this process, if necessary; and

(6) notifying the fiscal intermediary of the name, MassHealth RID number, address, and telephone number of the member, and the name, address, and phone number of the surrogate, if any, who is responsible for submitting, reviewing, and/or signing the activity forms.

(B) Functional Skills Training. Personal care agencies must provide members who have a prior authorization for PCA services, and their surrogates, with the functional skills training needed to successfully manage the PCA program and maximize the member's ability to self-direct care. The frequency and type of functional skills training that a member and the surrogate, if any, need must be documented in the member's service agreement.

(1) The PCA agency must provide functional skills training that includes, but is not limited to:

(a) PCA Training. The personal care agency must instruct the member and the surrogate, if any, in the functions and scheduling of PCAs in relation to the member's need;

(b) PCA Management. The personal care agency must instruct the member and the surrogate, if any, in:

(i) hiring, recruitment, training, and supervision of PCAs, including advertising for PCAs, and interviewing techniques;

(ii) methods for evaluating PCA competence and effectiveness and requesting assistance in dealing with training or other issues as necessary;

(iii) developing and maintaining a list of PCAs who can be used when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services; and

(iv) appropriate utilization of PCA services in accordance with 130 CMR 422.416(E).

(c) Personal Health Care Maintenance. The personal care agency must instruct the member and the surrogate, if any, about the respective roles of the member, PCAs, and others who assist the member in meeting personal health care needs and the respective abilities of each to:

(i) identify, understand, and describe medical conditions, problems, and susceptibilities; and

(ii) identify, understand, and describe routines and treatments including medication schedules and dosages, nutritional planning, bowel and bladder routine, and range-of-motion routine.

(d) Emergency Management. The personal care agency must instruct the member and surrogate, if any, to develop and review procedures to:

(i) describe how and when to use a physician and a local hospital emergency room;

(ii) identify and respond to the signs of an emergency;

(iii) understand the appropriate treatment, equipment, or action for dealing with an emergency;

(iv) maintain a list of emergency telephone numbers and procedures for use by the member, surrogate (if necessary), and PCAs; and

(v) assist the member in identifying and maintaining a list of back-up PCAs that are available to provide PCA services in an emergency.

(e) Skills Training Related to the Fiscal Intermediary. The personal care agency must instruct the member and the surrogate, if any, in:

(i) the role of the fiscal intermediary;

(ii) the requirement that the member select an employer option in accordance with 130 CMR 422.420(A)(1), including the member's right to receive assistance from the personal care agency in determining which employer option best meets their needs and abilities;

(iii) the appropriate and accurate use of activity forms (time sheets); and

(iv) the appropriate and accurate use of the forms contained in the fiscal intermediary's employment package (see 130 CMR 422.419(B)(14)(a)) on a face-to-face basis, when the fiscal intermediary is unable to provide sufficient explanation by telephone.

(2) To ensure timely and thorough functional skills training, the personal care agency must:

(a) respond within two business days to all requests from members or surrogates for functional skills training;

(b) provide face-to-face skills training when the member or surrogate requests a face-to-face visit with the skills trainer;

(c) provide face-to-face skills training on at least a quarterly basis to all members during the first year of approved PCA services; and

(d) provide face-to-face skills training to members within two business days of the request of the Division or the fiscal intermediary to resolve issues related to activity forms, utilization, completion of paperwork needed for payroll, and other PCA management issues.

(C) Payment.

(1) Payment for intake and orientation services is a per-member, per-month rate and is limited to a maximum of three consecutive months and only for members who are in the process of obtaining a prior authorization for PCA services.

(2) Payment for functional skills training is a per-member, per-month rate and is restricted to members for whom the personal care agency has obtained a prior authorization for PCA services, with the exception of consumer transfers. Rates for payment for intake and orientation and functional skills training are established by the DHCFP under 114.3 CMR 9.00 and are inclusive of activities described under 130 CMR 422.421.

422.422: PCA Program: Operating Procedures

(A) Assessment. For each member determined eligible for PCA services in accordance with 130 CMR 422.421(A)(2), the personal care agency must conduct a written assessment of the member's capacity to manage PCA services independently. The assessment must be in a standard format developed by the personal care agency subject to Division approval. The assessment process must include the member and may include participation of family members or other member representatives. The personal care agency must:

(1) based on a face-to-face visit with the member, conduct a written assessment of the member's ability to manage PCA services and to function as an employer of PCAs. The assessment must be conducted before submitting an initial request for prior authorization for PCA services to the Division. The result of an assessment is that the member either:

(a) is able to perform independently all tasks required to manage the PCA program. (The personal care agency will conduct a PCA evaluation and submit the request for prior authorization to the Division); or

(b) requires the assistance of a surrogate to perform some or all of the PCA management tasks that the member is unable to perform. (A surrogate must be identified before the personal care agency submits a prior authorization request to the Division.);

(2) review the assessment and modify it, as appropriate, at the time of the member's reevaluation;

(3) review the assessment and modify it, as appropriate, when:

(a) the member's medical, cognitive, or emotional condition changes in a way that affects the member's ability to manage PCA services independently;

(b) the member exhibits a pattern of overutilization of authorized PCA services, an inappropriate use of PCA services, or potential fraud, and does not discontinue such behavior after intervention from a skills trainer; or

(c) the member, the fiscal intermediary, or the Division requests review of an assessment;

(4) review the assessment with the member and obtain the signature of the member and the member's surrogate, if any. If the member does not agree with the assessment, provide a process for resolving the disagreement; and

(5) notify the Division and the fiscal intermediary in writing of any change in the member's assessment findings.

(B) Surrogates.

(1) If the personal care agency's assessment described in 130 CMR 422.422(A) determines that the member requires the assistance of a surrogate, the member will appoint a surrogate who meets the criteria described in 130 CMR 422.402 and who can assist the member to manage the PCA program in accordance with Division regulations and the member's service agreement. The personal care agency will document the name, address, telephone number, and relationship to the consumer on the MassHealth evaluation and submit it to the Division, along with the PA request for PCA services.

(2) If the personal care agency's assessment determines that the member requires the assistance of a surrogate, but the member cannot identify a surrogate, the personal care agency must assist the member in locating a surrogate.

(a) If a surrogate is identified and meets the criteria described in 130 CMR 422.402, the personal care agency must obtain the name, address, and telephone number of the surrogate and the surrogate's relationship to the member, and include this information on the MassHealth evaluation form when submitting the PA request for PCA services.

(b) If a surrogate is not available, the personal care agency will refer the member to an appropriate service provider, and will not submit a PA request to the Division.

(3) If a member's surrogate becomes unavailable at any time during the prior-authorization period, or the Division requires the member to replace the surrogate pursuant to 130 CMR 422.420(B)(5), the personal care agency must immediately notify the member of the need to locate another surrogate within 30 calendar days.

(a) If another surrogate cannot be identified within 30 calendar days, the personal care agency must notify the Division in writing and refer the member to an appropriate service provider.

(b) The Division may terminate a member's PCA services in accordance with 130 CMR 422.420(B) when a surrogate cannot be identified.

(4) If a member's capacity to independently manage PCA services changes during the prior-authorization period, the personal care agency will conduct an assessment in accordance with 130 CMR 422.422(A).

(a) If the assessment determines that the member requires a surrogate, the member will appoint a surrogate, and the personal care agency will notify the Division and the fiscal intermediary in writing of the name, address, phone number, and relationship to the consumer.

(b) If the personal care agency's assessment determines that the member needs a surrogate, but one cannot be identified within 30 calendar days of the assessment, the personal care agency must notify the Division and the member in writing, including a copy of the assessment, and refer the member to an appropriate service provider.

(c) If a surrogate cannot be identified, the Division may terminate the member's PCA services in accordance with 130 CMR 422.420(B).

(5) The personal care agency must provide the Division and the fiscal intermediary with the name, address, and phone number of the member's surrogate, and report any changes in surrogate information.

(C) Personal Care Agency: Evaluation to Initiate PCA Services.

(1) An evaluation team consisting of a registered nurse and an occupational therapist must conduct an initial evaluation, under the supervision of a registered nurse, only for members who meet the criteria described in 130 CMR 422.403(A), (B), and (C)(1) through (3). The evaluation must accurately represent the member's need for physical assistance with ADLs and IADLs. The evaluation team must consider the member's physical and cognitive condition and resulting functional limitations to determine the member's ability to benefit from PCA services.

(2) The evaluation must take place in the member's presence and in the member's actual or proposed place of residence in the community, or in the following locations, if these situations apply:

(a) at the transitional living program site where the member lives if the member has completed functional skills training, but is unable to find housing; or

(b) at a hospital or institution if the member has been hospitalized or institutionalized for an extended period, unless the Division exercises its option of conducting the initial evaluation in accordance with 130 CMR 422.416(D).

(3) All evaluations must be completed on the Division's evaluation form by either the registered nurse or the occupational therapist who conducted the evaluation.

(a) The completed evaluation must be reviewed, approved, and signed by the member (or the member's legal guardian or surrogate, as appropriate) and the member's prescribing physician or nurse practitioner. See 130 CMR 422.416 regarding documentation of the physician or nurse practitioner's authorization.

(b) The completed evaluation must be sent to the Division, with the documentation described in 130 CMR 422.416(A).

(4) The Division may defer or deny requests for prior authorization for PCA services where:

(a) the applicant does not meet the eligibility criteria defined in 130 CMR 422.403;

(b) the standard MassHealth personal care application and evaluation forms are not submitted or are incomplete;

(c) the evaluation provides insufficient information to determine if PCA services are medically necessary;

(d) the member or the surrogate has not signed the evaluation;

(e) there is not sufficient documentation to indicate that the physician or nurse practitioner has authorized PCA services;

(f) the surrogate information is not provided in the format requested by the Division, or the personal care agency has determined that a surrogate is required but one is not identified in the evaluation; or

(g) the services being requested in the evaluation are not covered under the MassHealth PCA program. (See 130 CMR 422.410, 422.411, and 422.412.)

(D) Reevaluation. Reevaluations must be conducted by a registered nurse and must include a review of the service agreement and the assessment. If appropriate, an occupational therapist may be involved in the process. Requirements cited in 130 CMR 422.422(C)(2) through (4) also apply to reevaluations.

(1) Except as described in 130 CMR 422.422(D)(2), reevaluations must be conducted annually, or more frequently when a significant change in the member's physical condition or living situation has occurred. The reevaluation must accurately represent the member's need for physical assistance with ADLs and IADLs, and must consider the member's physical and cognitive condition and resulting functional limitations to determine ability to benefit from PCA services.

(2) The Division may, at its discretion, grant prior authorization beyond the usual one-year period for services requested in a reevaluation in cases where the member:

(a) is aged 22 through 60;

(b) had no significant change in medical condition, functional status, or living situation within the previous year that may increase or decrease the member's need for PCA services, and no significant change is anticipated; and

(c) is not requesting an increase in the number of PCA hours provided per week.

(E) Authorization. The Division, at its sole discretion, may elect to conduct the PCA evaluation for purposes of authorizing PCA services in accordance with 130 CMR 422.416(D).

(F) Rates. Rates for payment for evaluations and reevaluations are set by DHCFP in accordance with 114.3 CMR 9.00 and are inclusive of all related activities specified in 130 CMR 422.422(A), (C), and (D), including, but not limited to, conducting the assessment and evaluations, obtaining necessary medical documentation, contacting the physician or nurse practitioner, and responding to Division inquiries or deferrals.

422.423: PCA Program: Service Agreement

(A) Before the initiation of PCA services, the personal care agency, in conjunction with the member and the member's surrogate, if any, must develop a written service agreement that is unique to the member and in a standard format developed by the personal care agency, subject to Division approval. The service agreement must include, at a minimum:

(1) a detailed description of the responsibilities of the PCA, the fiscal intermediary, the member, the surrogate, and the personal care agency;
(2) if a surrogate is required, the identity of the surrogate and a detailed description of the surrogate's responsibilities, including the PCA management tasks the surrogate will perform or assist the member to perform; and the frequency of the surrogate's visits to the member. The surrogate must perform these tasks in the best interest of the member, and in accordance with Division regulations. The service agreement will ensure the member's maximum participation in the management of the PCA tasks;
(3) if a surrogate is not required, the service agreement must clearly state that the member has the sole responsibility of managing the PCA services;
(4) the list of PCAs available when an unforeseen event occurs that prevents the member's regularly scheduled PCA from providing services, developed in accordance with 130 CMR 422.420(A)(15); and
(5) the type and frequency of functional skills training that the personal care agency will provide to the member, and the surrogate, if any, to manage PCA services effectively, based on the member's individual abilities and needs.

(B) Before implementing or modifying the service agreement, the personal care agency must provide to the member and surrogate, if any:
(1) a copy of the plan;
(2) an explanation, if necessary, of the terms of the plan;
(3) an opportunity to object to any terms of the plan; and
(4) a process to resolve any objections or disagreements as soon as possible, including an opportunity to meet with all interested persons.

(C) A review of the service agreement must include a review of the needs and circumstances of the member, the services provided by the PCA, and, if appropriate, the surrogate's management of the PCA.
(1) The personal care agency will review the service agreement with the member and surrogate, if any, before the initiation of PCA services and then at reevaluation, and modify as appropriate.
(2) The personal care agency will review the service agreement with the member, and surrogate, if any, on at least a quarterly basis, and modify, as appropriate, when the following occurs:

(a) the member has a surrogate;
(b) the member's surrogate changes;
(c) the member is in the first year of prior authorization for PCA services;
(d) the member or surrogate is not managing PCA services effectively, as evidenced by consistent overutilization, inappropriate submission of activity forms, difficulty in retaining PCAs, suspicion of fraud, or other indication that the member or surrogate is not able to manage PCA services;
(e) significant changes affecting the use of PCA services have occurred in the member's life;
(f) other circumstances warrant a review; or
(g) the member, the Division, or the surrogate requests a review.

(D) All service agreements and subsequent modifications and reviews must be signed by the parties involved.

(E) The personal care agency is responsible for monitoring the overall implementation of the service agreement.

(130 CMR 422.424 through 422.430 Reserved)

422.431: Transitional Living Program: Prior Authorization

A provider of transitional living services must obtain prior authorization from the Division as a prerequisite to payment for transitional living services. Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment. All requests for prior authorization for transitional living services must be submitted on the Division's forms in accordance with the billing instructions in Subchapter 5 of the *Personal Care Manual*. A completed assessment, evaluation, and service agreement prepared in accordance with 130 CMR 422.438 and 422.439 that are signed by both the member and the program's director must be submitted to the Division with a request for prior authorization.

422.432: Transitional Living Program: Notice of Approval or Denial for Transitional Living Services

(A) Notice of Approval. If the Division approves a prior-authorization request for transitional living services, the Division will send written notice to the member and the transitional living provider about the frequency, duration, and intensity of care authorized, as well as the effective date of the authorization.

(B) Notice of Denial and Right of Appeal.

(1) If the Division denies a prior-authorization request for transitional services, the Division will notify both the member and the transitional living provider. The notice will state the reason for the denial and will inform the member of the right to appeal and of the appeal procedure.

(2) If the Division denies a PA request for transitional living services, a member may appeal by requesting a fair hearing from the Division. The request for a fair hearing must be made in writing to the Division's Board of Hearings in accordance with the time lines described in 130 CMR 610.015(B). Requests for continuation of services during an appeal must be made in accordance with 130 CMR 610.036. The Division's Board of Hearings will conduct the fair hearing in accordance with 130 CMR 610.000.

422.433: Transitional Living Program: Scope of Services

A transitional living provider must, at a minimum, provide the following services in accordance with each member's needs as documented in the member's service agreement:

(A) transitional living services, as described in 130 CMR 422.431 through 422.441; and

(B) transportation to health-care facilities when public transportation is unavailable.

422.434: Transitional Living Program: Administrative Day Rate

If a member has completed the program of transitional living services but cannot secure an appropriate living arrangement, the Division will pay an administrative day rate covering the program's overhead expenses and the member's personal care services. The Division will pay this rate contingent upon documentation provided by the transitional living provider in the form and frequency determined by the Division.

422.435: Transitional Living Program: Leaves of Absence

(A) Medical Absence. If a member in a transitional living program is hospitalized, the Division will pay the transitional living provider for a maximum of 13 days per member per episode of hospitalization.

(B) Nonmedical Leave of Absence. If a member leaves the transitional living program for personal reasons, the Division will pay the transitional living provider for a cumulative maximum of 10 days of nonmedical leave of absence during the member's stay in the transitional living program.

422.436: Transitional Living Program: Staffing Requirements

The transitional living provider must have the following staff at each transitional living program site:

(A) a program director who must be on site for at least 20 hours per week;

(B) a registered nurse who must be on site at least 15 hours per week, and who must supervise functional skills training in matters of personal health care (see 130 CMR 422.437(C)) and PCA services provided at the transitional living site;

(C) an occupational therapist who will assist in the provision of functional skills training and in meeting the functional needs of program participants;

(D) skills instructors or peer counselors to provide functional skills training;

(E) a part-time driver who has a current, valid driver's license and is qualified to use adapted, accessible vehicles; and

(F) additional staff as necessary to meet individual health and health-related needs as detailed in the personal care services plan.

422.437: Transitional Living Program: Functional Skills Training

The need for and benefit from functional skills training is to be determined as part of the assessment described in 130 CMR 422.438(A). At a minimum, each service agreement must contain provisions and a schedule for functional skills training in the four areas listed below.

(A) PCA Training. PCA training must instruct the member and the member's surrogate, if any, in the functions and scheduling of PCAs in relation to the member's needs.

(B) PCA Management. The member and the member's surrogate, if any, will be instructed in:
(1) hiring of PCAs, including identification of local resources, advertising for PCAs, and interviewing techniques;
(2) use of time sheets and schedules in documenting the use of PCAs and meeting the requirements for reimbursement;
(3) methods for evaluating PCA competence and effectiveness and requesting assistance in dealing with training or other issues as necessary; and
(4) firing and replacing PCAs, including maintenance of a backup system as necessary.

(C) Personal Health Care Maintenance. The transitional living provider must instruct the member and the member's surrogate, if any, in the respective roles of the member, the PCAs, and others who assist the member in meeting personal health care needs and the respective abilities of each to:
(1) identify, understand, and describe medical conditions, problems, and susceptibilities; and
(2) identify, understand, and describe routines and treatments, including medication schedules and dosages, nutritional planning, bowel and bladder routine, and exercise/range-of-motion routine.

(D) Emergency Management. The transitional living provider must instruct the member and the member's surrogate, if any, to develop and review procedures to:
(1) describe how and when to use a physician and a local hospital emergency room;
(2) identify and respond to the signs of an emergency;
(3) understand the appropriate treatment, equipment, or action for dealing with an emergency; and
(4) maintain a list of emergency telephone numbers and procedures for use by the member, the member's surrogate, if necessary, and PCAs.

422.438: Transitional Living Program: Operating Procedures

(A) Assessment. The assessment identifies the member's needs and functional capabilities, including the ability to manage personal care services independently. For an individual who cannot manage personal care services independently, the assessment must identify a surrogate; if a surrogate is not available, the agency must refer the member to an appropriate service provider. The assessment process must include the member and may include participation of family members and advocates. The product of an assessment is either an evaluation or a referral to an appropriate service provider.

(B) Evaluation.

(1) An evaluation team consisting of a registered nurse and an occupational therapist must conduct an initial evaluation under the supervision of a registered nurse. The evaluation team must consider the member's physical and cognitive condition to determine the member's ability to benefit from PCA services. All evaluations are subject to the approval of the member's physician.

(2) The evaluation must take place in the member's actual or proposed place of residence in the community, or in the following locations, if these situations apply:

(a) at the transitional living program site where the member lives if the member has completed functional skills training, but is unable to find housing; or

(b) at a hospital or institution if the member has been hospitalized or institutionalized for an extended period.

(C) Reevaluations. At least annually, and when necessary in the event of a significant change in the member's physical condition or living situation, the registered nurse must conduct a reevaluation, including a review of the personal care services plan. For plans designating a surrogate, see 130 CMR 422.439(B). The reevaluation must conform to the requirements in 130 CMR 422.438(B). If appropriate, the occupational therapist must be involved.

(D) Processing Services. The transitional living provider must process Division payments for PCA services. The Division pays the agency, which transmits the funds to the member or the surrogate, who pays the PCA.

(1) The organization's administrator and the member both must sign an agreement on a form designated by the Division. This agreement states the member's and the agency's legal responsibilities in the transitional living program.

(2) Each pay period, not to exceed a month, the transitional living provider must collect activity forms from each member, signed by both the member and the PCA. The organization may claim payment from the Division only for services actually provided by the PCA as documented by the activity forms, plus the processing fee established by the DHCFP.

(3) Within four working days after receiving payment from the Division for PCA services, the transitional living provider must pay the member or the surrogate the amount owed to the PCA for these services.

(4) The agency must maintain a separate account exclusively for PCA payments. All such payments must be maintained in such account until disbursed to the member or surrogate.

(E) Nursing Supervision. The transitional living provider must provide nursing supervision of transitional living services as authorized in the service agreement and at least annually as part of an evaluation or reevaluation.

422.439: Transitional Living Program: Service Agreement

(A) (1) Before the initiation of PCA services, the transitional living provider, with the participation of the member and the surrogate (if any), must develop a written individual service agreement, which must describe in detail the responsibilities of the PCA, the member, the member's surrogate, and the transitional living provider.

(2) On the basis of an assessment as provided in 130 CMR 422.438(A), the transitional living provider, with the participation of the member to the fullest extent possible, must determine whether a surrogate is needed to manage the personal care services. If no surrogate is needed, the service agreement must clearly state that the member has sole responsibility to manage the PCA.

(3) If a surrogate is needed, the service agreement must name the surrogate, and pursuant to and as described in the service agreement, the member must be involved in managing the PCA to the maximum extent possible. The service agreement's description of the surrogate's responsibilities must include the frequency of the surrogate's visits with the member. The personal care agency is responsible for monitoring the overall implementation of the service agreement.

(4) Before implementing or modifying the service agreement, the transitional living provider must provide to the member or surrogate:

(a) a copy of the service agreement;
(b) an explanation, if necessary, of the terms of the agreement;
(c) an opportunity to object to any terms of the agreement; and
(d) a process to resolve any objections as soon as possible, including an opportunity to meet with all interested persons.

(B) Where the service agreement identifies the need for a surrogate, the organization, with the participation of the member and the surrogate, must review the service agreement and its implementation. Review of the agreement must include a review of the needs and circumstances of the member, the services provided by the PCA, and the surrogate's management of the PCA. If necessary, the plan will be modified:

(1) at least every three months;
(2) when there is a change in the surrogate;
(3) when other significant changes in circumstances necessitate it; and
(4) whenever requested by the member or the surrogate.

422.440: Transitional Living Program: Physical Plant

Each transitional living program site must be inspected and approved by the Division before its use in providing the program. Each site must, at a minimum, meet the following standards.

(A) The site must be accessible to and suitable for persons with multiple physical disabilities.

(B) The site must comply with the laws and regulations of the Architectural Access Board.

(C) There must be documentation of a site inspection and approval by the Massachusetts Department of Public Safety, local fire department, and building inspector, and compliance with all applicable federal, state, and local statutes, laws, and ordinances.

(D) Members' quarters must be near to and easily accessible from staff and attendant quarters.

(E) The site must have an accessible, appropriate telephone or emergency call device located in each bedroom.

422.441: Transitional Living Program: Emergency Procedures

(A) Each member must know how to contact program staff and attendants in case of an emergency.

(B) An emergency evacuation plan must be in effect, practiced by all members, and provide for evacuation of members who cannot exit unassisted.

(130 CMR 422.442 through 422.445 Reserved)

422.446: Recordkeeping Requirements

Providers of any service covered under 130 CMR 422.000 must maintain, for at least four years after the date of service, records for each member that include at least the following;

(A) the member's name, social security number (SSN), address, telephone number, case number, member identification number (RID), sex, date of birth, marital status, and next of kin;

(B) the name, address, and telephone number of the surrogate, where applicable;

(C) the date of the member's first contact with the personal care agency;

(D) a copy of the Division's written authorization regarding the frequency, duration, and intensity of care to be provided;

(E) the name and address of the member's primary physician or medical clinic; and

(F) any other records required by the provider's contract with the Division.

422.447: Billing Responsibility

Providers of any service covered under 130 CMR 422.000 are responsible for billing the Division for the personal care services listed in 130 CMR 422.000 in accordance with Subchapter 5 of the *Personal Care Manual*.

422.448: Rates of Payment

Except for the administrative fee paid to fiscal intermediaries, the Division pays for personal care services covered under 130 CMR 422.000 at the rates set by DHCFP in accordance with 114.3 CMR 9.03 and 114.5 CMR 4.00.

REGULATORY AUTHORITY

130 CMR 422.000: M.G.L. c. 118E, §§ 7 and 12.